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RIGHTS AND RESPONSIBILITIES OF PATIENTS

RIGHTS

As a Patient, I have the RIGHT to:

1. Full information about my rights and responsibilities as a patient in an Ambulatory Clinic;
2. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued;
3. An explanation of all rules, regulations and services provided by the Clinic, the days and hours of service and provisions for possible emergency care, including telephone numbers;
4. Choose my own physician, and know the names, status and experience of the staff;
5. Participate in development of a plan of care including Advance Directives and have my own copies;
6. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previously given consent for further treatment;
7. Disclosure of any teaching programs, research or experimental programs in which the facility is participating;
8. Full financial explanation and payment schedules prior to beginning treatment;
9. Receive expert, professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age;
10. Be treated with courtesy, dignity and respect of my personal privacy by all employees of the Clinic;
11. Be free of physical/mental abuse and/or neglect by all employees of the Clinic;
12. Complain or file grievance with the Clinic Administrator (phone number: 210-424-1600) without fear of retaliation or discrimination;
13. Confidential treatment of my condition, medical record and financial information;
14. Access to my personal records and obtain copies upon written request; and,
15. Assistance and consideration in the management of pain.

RESPONSIBILITIES

As a Patient, I have the RESPONSIBILITY to:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items;
2. Participate in developing a Plan of Care, Advance Directives and Living Will;
3. Assist in maintaining a safe, peaceful and efficient ambulatory environment;
4. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed upon co-pay during my office visit.
5. Contact the Clinic 24 hours prior to my appointment when unable to keep a scheduled appointment;
6. Cooperate in the planned care and treatment developed for me;
7. Request more detailed explanations for any aspect of service I do not understand;
8. Inform my physicians and nurses of any changes in my condition or any new problems or concerns;
9. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the Clinic staff; and
10. Relate my levels of discomfort and/or pain and perceived changes in my pain management to my physician.
11. Inform my physician or nurse when I am going to need a prescription refill before my supply is gone.

The following agencies may be contacted to file a grievance against a nurse or physician:

Nurse: Texas Board of Nursing; P.O. Box 430; Austin, Texas 78767; (512) 305-7400
Physician: Texas Board of Medical Examiners; 1812 Centre Creek Dr.; Austin, Texas; (800) 201-9353

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NOTICE OF PRIVACY PRACTICES

Effective Date: 4/1/03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us

In this Notice, we use terms like "we," "us" or "our" to refer to Texas Oncology–San Antonio, its physicians, employees, staff and other personnel. All of the sites and locations of Texas Oncology–San Antonio follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify the Practice Manager at 210-424-1600.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to the Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact Practice Manager at 210-424-1600.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Practice Manager, 100 N.E. Loop 410, #600, San Antonio, TX 78216, 210-424-1600. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the patient waiting area. Each version of the Notice will have an effective date listed on the first page.

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MEDICARE FACT SHEET

Dear Patient:

Our primary concern as your oncologist/hematologist is to provide you with the very best care possible. Our office staff and we understand that medical insurance, especially Medicare, can be confusing. If you need any assistance, we are here to help you.

The following information describes Medicare's rules in paying for your services. Medicare, Part B, covers physician's bills for office visits, treatments, diagnostic tests, hospital visits, etc. Part A is for hospital bills. It is your Part B Medicare coverage that pays for your medical charges.

Each year Medicare asks us to decide if we want to be a participating or nonparticipating physician. Once we choose to do so, there are certain rules we must follow and that our patients need to know.

In 2005, our decision is to be participating physicians. That means we have agreed to "accept assignment" on all Medicare claims. This is a business decision and not a medical decision. It does NOT affect the quality of care that you get from us.

What Does "Accept Assignment" Mean?

Accepting assignment means accepting the Medicare allowed amount as the TOTAL charge for any given procedure. It also means that we agree to do the billing to Medicare for you. As participating physicians, we must accept assignment on all care given.

What is a Deductible?

Each calendar year (January 1-December 31) the beneficiary is responsible for a specific amount of money for all Part B services before Medicare will begin to pay for any health care bills.

Sometimes a supplemental insurance rather than the beneficiary will cover the deductible. In either case the full annual deductible must be paid before Medicare begins to cover any Part B Medical bills.

The deductible may be met by one medical bill or by medical bills from several different physicians. Once the total deductible is paid, it cannot be collected again for that year.

What is Co-Payment?

If Medicare feels that services we bill are covered under its policy, it will pay 80% of the allowed amount of that bill. For example, if $20.00 is allowed, $16.00 will be paid by Medicare (80% of $20.00). Generally your supplemental insurance (Medi-gap) is responsible for the remaining 20% ($4.00) of the bill. This $4.00 is the co-payment.

The co-payment applies to any kind of Part B service (office visit, treatment, etc.), and goes into effect AFTER you have paid your annual deductible. All doctors are required by Medicare to collect the co-payment.

What Else Might I Have To Pay For?

All patients have to pay the annual deductible as well as a 20% co-payment for both participating and nonparticipating. Because we are participating physicians and accept assignment on all Medicare services, there will be no additional fees for services covered by Medicare. Occasionally, your physician may feel that it is medically necessary to perform a test or treatment that is not covered by Medicare payment. You will be informed of the non-covered service PRIOR to the service

being provided. At that time you will be asked to sign a waiver of liability form which indicates that you acknowledge that you will be responsible for 100% of the charge for this test or service. You will also be informed of the estimated expense to you.

How Do I Pay My Medical Bill?

Medicare will pay 80% of the allowed amount directly to us on any assigned claims that Medicare feels are covered. After the Medicare payment is received in our office, your supplemental insurance carrier is billed for the balance. If you have no supplemental carrier, we will bill you for the remaining 20% co-pay. You will receive a bill monthly for the portion of the medical bill that you owe to us. We would appreciate your prompt payment of this account. If you are unable to pay the entire balance in one payment, please request a meeting with the financial counselor. The financial counselor will assist you with payment arrangements.

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ADVANCE DIRECTIVES QUESTIONS AND ANSWERS

What are Advance Health Care Directives?
Each of us has the right to determine the course of our medical care and treatment. Advance Health Care Directives are documents enabling us to declare our wishes about the care we receive, in case we become unable to speak for ourselves. These documents may include the Living Will and the Durable Power of Attorney for Health Care.

Why do we need Advance Directives?
Frequent court battles over these issues prove that the law requires clear and convincing proof of an individual's health care decisions and directions. An advance health care directive is currently the strongest way to provide that proof.

How do Advance Directives differ?
All are similar in purpose, but there are differences. All should be signed and witnessed. Only the Durable Power of Attorney for Health Care requires notarization.
A Living Will is a legal document expressing wishes, that in the event of prolonged and irreversible illness or injury, the party signing the Living Will shall be allowed to die without the use of life-prolonging medical procedures. Living Wills have traditionally been used by persons with terminal illness. A lawyer is not needed to draw up a Living Will, but legal consultation may be advisable. This document provides very specific instructions to your health care providers.
Under Durable Power of Attorney for Health Care, someone is appointed to make decisions about your medical care when you are unable to make the decision yourself, due to an incapacitating physical or mental illness. Durable Power of Attorney is also called Health Care Proxy or Appointment of Health Care Agent. This document leaves the decisions more open to the Health Care Proxy and is not as specific as the Living Will. Unless a period of validation is specified, the proxy is valid indefinitely. The Health Care Proxy is not held liable for the cost of your care due to his/her decisions as proxy.

Can I change or revoke my Advance Directive?
Any competent adult can change or revoke a directive at any time. This is usually done in writing, but may also be done verbally. The previous advance directive should be destroyed and replaced with a new document, and the appropriate persons should be notified of the change.

How do Advance Health Care Directives laws affect this facility?
In compliance with the Patient Self-Determination Act of 1990, this facility supports the rights of patients to make health care decisions through use of documents such as, the Living Will, Advance Health Care Directives, and Durable Power of Attorney for Health Care.
Upon becoming a patient with Texas Oncology–San Antonio, all competent adults are asked if they have an Advance Health Care Directive. The form used to document this information is called the Advance Health Care Directives Admissions Form (see reverse page). The form is given to patients by the staff at the first visit. Patients may ask questions or request help in completing advance directives.

What is meant by "competent adult"?

The word competent is not intended as a legal term. It is used to mean an adult able to understand the purpose and content of the Advance Health Care Directives.

What are the responsibilities of the clinic staff to address Advance Health Care Directives?
All competent adult patients must be informed about Advance Health Care Directives and asked whether they have this document at the time of registering as a new patient with Texas Oncology–San Antonio. The Advance Health Care Directives Admissions Form is used to document these activities.

Responsibilities of the clinic staff
The clinic staff is instructed to know the different types of advance directives. Each knows where to direct patients who have questions or want more information about advance directives. If a patient has provided advanced directives to Texas Oncology–San Antonio, the physicians and staff should know the patients decisions related to treatment.

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ADVANCE HEALTH CARE DIRECTIVES ADMISSIONS FORM

May be read to the patient

In compliance with the Patient Self-Determination Act of 1990, Texas Oncology–San Antonio has written policies respecting the importance of an individual's right under Texas law to make decisions concerning medical care. The rights include the right to accept or refuse medical or surgical treatment and the right to formulate Advance Health Care Directives. In the state of Texas, any person 18 years of age or older who is legally competent, has the right to make decisions in advance about his or her health care. These decisions can range from routine to life-sustaining treatment including, the provision of food and water.

Written instructions can include Advance Health Care Directives, Living Will, or Durable Power of Attorney for Health Care. Advance Health Care Directives instruct the health care provider with a patient's decisions pertaining to medical care and treatments in the event the patient cannot make decisions for himself or herself. No person can be discriminated against, or have care conditioned upon whether he or she has executed advance directives. Advance Health Care Directives are effective until the time of death or until they are revoked.

Advance Health Care Directives *options*

☐ **Yes**, I have Advance Health Care Directives.

- ☐ A current copy of my Advance Health Care Directives **has** been given to this health care facility.
- ☐ A current copy of my Advance Health Care Directives **has not** been given to this health care facility. I understand that it is my responsibility to provide this health care facility with a copy of my Advance Health Care Directives.

☐ **No**, I do not have Advance Health Care Directives. I understand that I can request more help and information about advance directives.

- ☐ I have received informational material about advance directives.
- ☐ I prefer not to receive informational material about advance directives.
- ☐ I would like to speak to someone regarding advance directives.

Patient signature _____ Date _____

Two copies of this form are enclosed. Please complete both, and **return** one copy on your next visit, and please **retain** one copy for your records.

For Texas Oncology–San Antonio use only
Patient would not OR was unable to sign this document.

RN signature _____ Date _____